

# Patient-Centered Medical Home Qualification Standards

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# Why qualification standards?

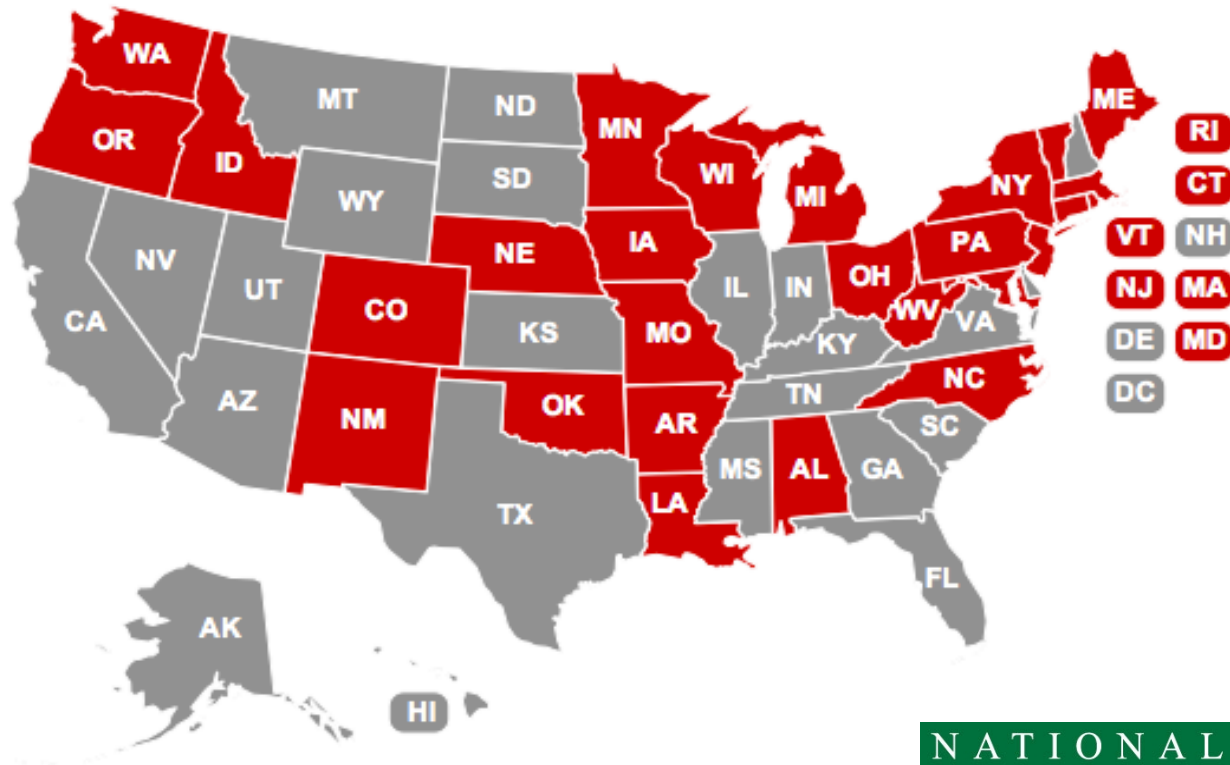
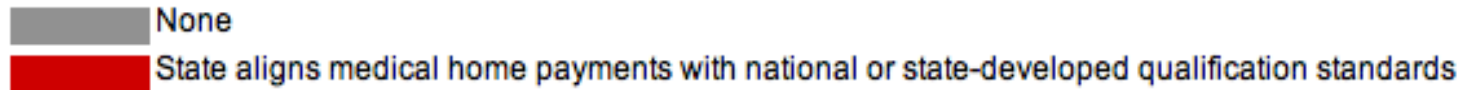
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- ❖ What is a medical home?
- ❖ Raising the bar for primary care practices

# 27 States Tie Payments to Qualification Standards

## Qualification Standards

States aligning medical home payment with national or state-developed qualification standards



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# Types of PCMH Qualification Standards

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- ❖ National Standards
- ❖ State-Developed Standards
- ❖ Hybrid
- ❖ Practice tools

# National Standards

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- ❖ NCQA PCMH Recognition
- ❖ Joint Commission PCMH Certification
- ❖ URAC PCMH Achievement
- ❖ AAAHC Certification and Accreditation

# National Standards Crosswalk

	NCQA	Joint Commission	URAC	AAAHHC
<b>Overview</b>	27 elements across 6 categories (6 must-pass elements)	43 elements across 12 categories (all standards required)	28 elements across 7 categories (7 must-pass elements)	8 core standards and 19 additional standards based on services provided by practice
<b>Tiers</b>	3 (based on score)	Pass/Fail	2 (based on electronic health record)	Certification (lower)/Accreditation (higher)
<b>Electronic Health/Medical Record Requirement</b>	Not for recognition, but some standards would require use	Use of information technology required, but not necessarily EMR	Only for "Achievement with EHR Designation"	No, although electronic data management is encouraged.
<b>Length</b>	3 years	Up to 3 years	2 years	Up to 3 years

Crosswalk adapted from/Additional information available at: <http://www.pcdc.org/assets/pdf/09-09-11-crosswalk-of-medical-home-stds.pdf>;  
[www.ncqa.org](http://www.ncqa.org); [www.jointcommission.org](http://www.jointcommission.org); [www.urac.org](http://www.urac.org); [www.aaahc.org](http://www.aaahc.org).



# NCQA PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity		Pts
A. Access During Office Hours**		4
B. After-Hours Access		4
C. Electronic Access		2
D. Continuity		2
E. Medical Home Responsibilities		2
F. Culturally and Linguistically Appropriate Services		2
G. Practice Team		4
		20
PCMH2: Identify and Manage Patient Populations		Pts
A. Patient Information		3
B. Clinical Data		4
C. Comprehensive Health Assessment		4
D. Use Data for Population Management**		5
		16
PCMH3: Plan and Manage Care		Pts
A. Implement Evidence-Based Guidelines		4
B. Identify High-Risk Patients		3
C. Care Management**		4
D. Manage Medications		3
E. Use Electronic Prescribing		3
		17

PCMH4: Provide Self-Care Support and Community Resources		Pts
A. Support Self-Care Process**		6
B. Provide Referrals to Community Resources		3
		9
PCMH5: Track and Coordinate Care		Pts
A. Test Tracking and Follow-Up		6
B. Referral Tracking and Follow-Up**		6
C. Coordinate with Facilities/Care Transitions		6
		18
PCMH6: Measure and Improve Performance		Pts
A. Measure Performance		4
B. Measure Patient/Family Experience		4
C. Implement Continuously Quality Improvement**		4
D. Demonstrate Continuous Quality Improvement		3
E. Report Performance		3
F. Report Data Externally		2
		20

\*\* Must Pass Elements

# NCQA PCMH 2011 Scoring

6 standards = 100 points  
6 *Must Pass* elements

**NOTE:** *Must Pass* elements require a  $\geq 50\%$  performance level to pass

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	85 - 100	6 of 6
Level 2	60 - 84	6 of 6
Level 1	35 - 59	6 of 6
Not Recognized	0 - 34	< 6

Practices with a numeric score of 0 to 34 points and/or achieve less than 6 “Must Pass” Elements are not Recognized.



# NCQA PCMH Recognition

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- ❖ Next update scheduled March 2014
  - Further integrate behavioral health
  - Focus on resource stewardship
  - Encourage sustained commitment to continuous quality improvement and PCMH transformation
  - Expanded emphasis on care coordination and transitions
  - Encourage shared-decision making and incorporate the patient, family, and caregivers into care planning
  - Maintain alignment with Meaningful Use and encourage information exchange

# State-Developed Standards

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- ❖ Some states have built their own requirements.
  - Oregon (Patient-Centered Primary Care Homes)
    - 6 Core Attributes
      - Access, Accountability, Comprehensiveness, Continuity, Coordination/Integration, and Patient/Family Centeredness
    - 3 Tiers
      - **Basic:** Foundational Structures and Processes
      - **Intermediate:** Demonstrated Performance Improvement and Additional Structures and Processes in Place
      - **Advanced:** Population Management and Accountable for Quality, Utilization and Cost
    - Accepts NCQA – although these practices need to submit additional information specific to the state program.

# New York's Health Home Standards

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- ❖ Partnership model with a lead health home agency partnering with additional providers in the community (“downstream providers”).
- ❖ Standards:
  - Comprehensive Care Management: Creation, documentation, and execution of an individualized, patient-centered care plan.
  - Care Coordination and Health Promotion: Assigned care manager for each patient.
  - Comprehensive Transitional Care: Prompt notification of admissions, discharges, and transfers.
  - Patient and Family Support: Care plan must be accessible to patients and families; must also reflect patient preferences and show cultural competency
  - Referral to Community and Social Support Services: Identification of and collaboration with community-based resources and social support services.

# Hybrid Standards

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## “NCQA-Plus”

### Maine

- ❖ Requires NCQA + 10 additional standards
  - Select examples:
    - ❑ Behavioral health integration
    - ❑ Population risk-stratification and management
    - ❑ Team-based care
    - ❑ Inclusion of patients & families in redesign
    - ❑ Focus on cost containment and waste reduction in QI activities
    - ❑ Integration of health IT
    - ❑ Connection to community resources

### Missouri

- ❖ As part of primary care health home program, required qualifying practices to achieve higher scores for certain standards.
- ❖ Example: NCQA requires a score of 50% to meet a “must-pass” element. Missouri required the practice to score 75% – requiring the practice to meet additional factors within the standard.

# Massachusetts' Primary Care Payment Reform Initiative (PCPRI)

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- ❖ Requires NCQA Level 1 within 24 months, plus additional core competencies, HIT, and care management standards.
  - Patient-centeredness, multi-disciplinary care teams, population management, care management for high-risk patients, and patient-self management support
- ❖ Comprehensive Primary Care Payment (CPCP) Tiers based on the level of behavioral health services in practices.
  - **CPCP Tier 1:** Practice provides no behavioral health services
  - **CPCP Tier 2:** Practice provides minimum set of behavioral health services
    - Includes full-time on-site behavioral health provider onsite
  - **CPCP Tier 3:** Practice provides maximum set of behavioral health services
    - Includes 0.2 FTE psychiatrist on-site, 24/7 access to behavioral health services, and basic behavioral health services included in EHR

# Key Takeaways

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- ❖ Qualification standards provide assurance to payers
- ❖ Qualification standards can be meaningful or they could merely be a paperwork exercise
- ❖ Becoming qualified as a medical home is hard work
- ❖ Plenty of opportunities to customize standards to meet your delivery system goals

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## TOPICS

- ACA Implementation & State Health Reform
- Coverage and Access
- Federal/State Issues
- Medicaid and CHIP
- Population and Public Health
- Providers and Services
- Quality, Cost, and Health System Performance
- Specific Populations

## PROGRAMS

ABCD Resource Center  
Access and the Safety Net  
Behavioral Health Evidence-Based Practices & Medicaid  
Children's Health Insurance  
Maximizing Enrollment  
**Medical Home & Patient-Centered Care**

## TOOLS & RESOURCES

Children's Coverage Toolbox  
Multi-Payer Resource Center  
State Accountable Care Activity Map  
Patient Safety Toolbox

## QUICK LINKS

NASHP Projects & Programs  
NASHP Publications by Date  
NASHP Authors' Publications

## Medical Home & Patient-Centered Care



Best viewed in Internet Explorer, Safari, or Chrome

A medical home is an enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care. First advanced by the American Academy of Pediatrics in the 1960's, the concept gained momentum in 2007 when four major physician groups agreed to a common view of the patient-centered medical home (PCMH) model defined by seven "Joint Principles." (For more information on the "Joint Principles" please go to [www.pcpcc.net](http://www.pcpcc.net).) Since 2007, NASHP has been tracking and supporting state efforts to advance medical homes for Medicaid and CHIP participants. NASHP's medical home map allows you to click on a state to learn about its efforts. Our work is supported by The Commonwealth Fund.

As of April 2013, 43 states have adopted policies and programs to advance medical homes. Medical home activity must meet the following criteria for inclusion on this map:

## Follow NASHP



## MEDICAL HOME STRATEGIES

Forming Partnerships  
Defining and Recognizing Medical Homes  
Aligning Reimbursement & Purchasing  
Supporting Practices  
Measuring Results

## MEDICAL HOMES PUBLICATIONS

Five Key Strategies to Engage Health Care Payers and Purchasers in a Multi-Payer Medical Home Initiative  
September 2013

Issue Brief: State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives  
July 2013

Care Management for Medicaid Enrollees Through Community Health Teams  
June 2013

[more](#)

Please visit:

- [www.nashp.org](http://www.nashp.org)
- <http://www.nashp.org/med-home-map>
- <http://www.nashp.org/state-accountable-care-activity-map>
- [www.statereform.org](http://www.statereform.org)
- [www.pcpcc.net](http://www.pcpcc.net)

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